AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Department of Central Management Services, Bureau of Benefits
616 Stratton Office Building Springfield, Illinois 62706 FAX: 217-524-7541

I, _____ _____
(Print First and Last Name) (Membership Number)

hereby authorize _____ to disclose protected health information related to
(Entity, Name, Plan Administrator, etc.)
services provided in connection with my medical treatment.

This medical information may be disclosed to:

Personnel within the Bureau of Benefits, Benefit Plan Administrators with which the department contracts and other individuals (specify, if applicable) _____ assisting me with this request.

Describe the information to be used or disclosed.

_____

Indicate the reason for the release or request of information:

At the Request of the Individual or Personal Representative

Other: _____

I understand that if I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that:

- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- I may revoke this authorization at any time by written notification to the entity listed above. My revocation will have no effect on information that has been released under this authorization prior to receipt of my intent to revoke such authorization.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- I am entitled to a copy of this authorization upon signature.

This authorization expires on _____.
(Date)

Signature: _____ Date Signed:_____

If a personal representative executes this form, that representative warrants that he or she has authority to sign this form on the basis of _____.
(Parent, Guardian, Power of Attorney, or other Authorized Representative)

_____ _____
(Signature) (Date)